564 E. Woolbright Road
Boynton Beach, FL 33435

Phone: (561) 735-6553
Fax: (561) 735-7739

Patient Information:

What is the reason for today's visit? _____

Legal Name (First, MI, Last):_____ Social Security: _____

Marital Status: ☐ Single ☐ Divorced/Separated ☐ Married ☐ Widowed ☐ Domestic Partner

Date of Birth:_____ Gender: ☐ Male ☐Female

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American Ethnicity: ☐ Hispanic or Latino

☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Non-Hispanic or Latino

Address: _____ Apt: _____ Home Phone: (_____)_____

City/State: _____ Zip: _____ Mobile Phone: (_____)_____

Employer: _____ Occupation: _____

Address: _____ City/State: _____

Zip: _____ Work Phone: (_____)_____

Spouse Name: _____ Primary Phone: (_____)_____

Social Security: _____ Date of Birth: _____ Work Phone: (_____)_____

Primary Insurance: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

Responsible Party: (Custodial parent if patient is under 18 years of age)

Legal Name (First, MI, Last): _____ ☐ MR ☐ MRS ☐ MS ☐ MISS

Social Security: _____ Date of Birth: _____

Address: _____ Apt: _____ Primary Phone: (_____)_____

City/State: _____ Zip: _____ Work Phone: (_____)_____

**Emergency Contact Name: _____ Relationship to Patient: _____

Mobile Phone: (_____)_____ Home Phone: (_____)_____

How did you hear about Genesis Community Health?

☐ Family/Friends ☐ Health Plan ☐ Radio ☐Newspaper ☐ Internet ☐ Phone Book

☐ Location ☐Dr. Referral ☐Health Fair ☐ Self Referral ☐ Other: _____

PLEASE READ THE FOLLOWING CAREFULLY

ALL HEALTH CENTER CHARGES ARE DUE AND PAYABLE WITHIN 30 DAYS OF BILLING DATE

The health center will automatically bill several major insurance companies. Please verify that your insurance company is one of them. Insurance claims are completed as a courtesy to you, without charge. **The health center does not accept the responsibility for collecting your claim or negotiating a settlement on a disputed claim.**

Copays are due at the time of the appointment. If you arrive unprepared to make your copay, you may be charged an additional copayment billing charge.

You are responsible directly to the health center for payment of your account within the time limit set, regardless of the status of your insurance claim.

If you do not have insurance, we have a sliding fee scale program that will determine your total office charges based on your verified income. If you need information about this program please see the receptionist.

Genesis Community Health may charge a fee for failed appointments. A 24 hour advance notice for cancellations or to reschedule is expected.

*** Balances over 90 days old may be assessed a $5.00 per month re-bill charge until the overdue balance is paid in full. ***

I authorize the release of any medical information necessary to process my insurance claims. I authorize payment of medical benefits to Genesis Community Health. I understand that I am financially responsible to Genesis Community Health charges not covered in the assignment.

I understand that the above health center policy and agree to accept responsibility for full payment of my account.

Patient/Guardian Signature: _____ Relationship to Patient: _____

Print Patient Name: _____ Date: _____